BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **Paul B. Plowman, M.D.** Holder of License No. 36272 For the Practice of Allopathic Medicine In the State of Arizona	Case No. MD-09-0879A MD-09-1011A MD-09-1033A **ORDER FOR LETTER OF REPRIMAND AND CONSENT TO THE SAME**

Paul B. Plowman, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for Letter of Reprimand; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 36272 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-09-0879A after receiving a complaint regarding Respondent's care and treatment of a 15 year-old female patient ("RL") alleging failure to maintain adequate medical records, falsifying medical records, failure to obtain informed consent, failure to provide adequate follow up care, and failure to obtain necessary testing. During the course of the investigation, an additional allegation was identified regarding Respondent's care and treatment of a 17 year-old female patient ("AF"). The Board also initiated case number MD-09-1011A after receiving a complaint regarding Respondent's care and treatment of a 27 year-old female patient ("TD") alleging failure to properly perform liposuction and failure to provide a copy of the complete medical record to the patient upon written request. The Board also initiated case number MD-09-

1033A after receiving a complaint regarding Dr. Plowman's care and treatment of a 60-year old female patient ("KH") alleging failure to properly perform a tummy tuck.

4. On June 15, 2009, RL underwent vulvectomy performed by Respondent with extensive condylomata acuminata. Respondent evaluated RL months prior to the June 15, 2009 procedure, but did not re-evaluate the patient prior to taking her to the operating room. RL had significant blood loss with postoperative hemoglobin of 9.0 and hematocrit of 25.9, and required medications for maintenance of her blood pressure. RL developed a fever and was diagnosed with septic shock as well as a soft tissue infection that required antibiotics, debridement and eventual skin grafting. The Medical Consultant ("MC") opined that Respondent's procedure far exceeded recommendations for surgical removal of genital warts with significant complications occurring.

5. On June 17, 2009, AF was admitted to the hospital in labor with spontaneous rupture of membranes. AF was augmented with Pitocin and monitored for adequacy of labor. A vacuum extraction was carried out when AF dilated to a rim. There was no evidence that the second stage of labor was allowed to progress on its own. No harmful outcome to the fetus was noted and AF's maternal anemia was treated with iron. Respondent did not document the reasoning for intervention, but noted the fetus had only descended to +1 station. The MC expressed concern with Respondent's aggressive approach used in the second stage of AF's delivery.

6. On June 13, 2008, Respondent performed liposuction on TD; however, Respondent's operative report was not contained in the records pertaining to the procedure. TD's postoperative course was complicated by a seroma, infection, and an overlap of the wound edges on the left side of the incision. On August 1, 2008, Respondent performed revision surgery on TD, with substandard results. The MC found

that Respondent performed the procedure in a substandard fashion with substandard results.

7. The standard of care when undertaking treatment for extensive vulvar condylomata requires a physician to determine whether dysplastic changes are present.

8. Respondent deviated from the standard of care because he did not obtain biopsies to determine if a dysplastic process was present prior to taking RL to the operating room.

9. The standard of care requires a physician to discuss options of treatment with the patient, including potential complications.

10. Respondent deviated from the standard of care because he did not discuss with RL the options of treatment and potential complications.

11. The standard of care requires a physician to render treatment based upon the patient's wishes as well as the severity of the disease process and expected success rate.

12. Respondent deviated from the standard of care because he did not appreciate the severity of the complications of the surgery performed on RL, and when complications occurred, the evaluation and treatments were incomplete.

13. The standard of care requires a physician to not perform a staged procedure to obtain an acceptable result.

14. Respondent deviated from the standard of care because he performed a staged procedure on TD to obtain an acceptable result.

15. The standard of care requires a physician to wait an appropriate amount of time prior to performing a revision surgery after performing liposuction on the patient.

16. Respondent deviated from the standard of care because he waited only six weeks before performing revision surgery on TD.

17. RL's vulvectomy involved significant blood loss that required transfusions, and septic shock and dehiscence of the wound that required debridement and eventual skin grafting. RL underwent numerous surgical procedures under anesthesia. Due to the extensive nature of initial and subsequent surgeries, RL may develop scarring and pain. TD underwent unnecessary surgery that resulted in a substandard post-operative result. TD also underwent an unnecessary secondary surgery with a substandard result. The ill-timed second surgery may have been a contributing factor in TD's post-operative pain complaints due to the surgery being performed during a time of maximal inflammatory response during the post-operative period. TD may require a third surgery to obtain a satisfactory result.

18. Respondent performed surgeries on KH on February 20, 2009 and March 6, 2009 and a revision on May 29, 2009. By Respondent's report, Respondent's medical records for this patient were stolen and; therefore, Respondent failed to maintain adequate medical records as required by statute.

19. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. §32-1401(2). Respondent's records were inadequate because he did not document informed consent for RL's vulvectomy. Respondent did not document the reasoning for intervention with AF's delivery. There was no operative report present from TD's first surgery, and Respondent did not document a discussion or plan regarding the staged procedure.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. §32-1401(27)(a) - Violating any federal or state laws or rules and regulations applicable to the practice of medicine. A.R.S. §12-2297 Retention of records

A. Unless otherwise required by statute or by federal law, a health care provider shall retain the original or copies of a patient's medical records as follows:

If the patient is an adult, for at least six years after the last date the adult patient received medical or health care services from that provider.

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. §32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient.").

4. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT Respondent is issued a Letter of Reprimand.

DATED AND EFFECTIVE this 14TH day of APRIL, 2010.

ARIZONA MEDICAL BOARD

(SEAL)

By _____
Lisa S. Wynn
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. Respondent consents to the entry of the order set forth above as a compromise of a disputed matter between Respondent and the Board, and does so only for the purpose of terminating the disputed matter by agreement. Respondent acknowledges it is the Board's position that, if this matter proceeded to formal hearing, the Board could establish sufficient evidence to support a conclusion that certain aspects of Respondent's conduct constituted unprofessional conduct. Respondent agrees not to contest the validity of the Findings of Fact and Conclusions of Law contained in the Order in an present or future administrative proceedings before the Board (or any other state agency in the State of Arizona, concerning the denial or issuance of any license or registration required by the state to engage in the practice or any business or profession.)

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any

modifications to this original document are ineffective and void unless mutually approved by the parties.

7. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

8. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

9. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

10. Any violation of this Order constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

DATED: 3/15/10

Paul B. Plowman, M.D.

EXECUTED COPY of the foregoing mailed this 15th day of April, 2010 to:

Stephen W. Myers
Myers & Jenkins
One E. Camelback Road, Suite 500
Phoenix, AZ 85012

EXECUTED COPY of the foregoing mailed this 15th day of April, 2010 to:

Paul B. Plowman, M.D.
Address of Record

ORIGINAL of the foregoing filed

this 5th day of April, 2010 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Arizona Medical Board Staff